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Emergency Conditions. The education sector, like all other sectors in the PA, has to cope with the constant fiscal crisis and the fluctuating availability of financial resources. The uncertainty of resource availability leads to a piecemeal approach and a proliferation of uncoordinated projects that have limited impact on the system and do not build the institutional capacity needed to make the interventions sustainable. In addition, the education system has to operate under restrictions imposed by closures, which result in a forced redeployment of teachers.

In the short term, the main challenge for the education system is to meet the financial requirements for keeping the school system operational. Considering that 90 percent of system expenditure is on salaries, finding the mechanisms to guarantee payment of teachers' salaries is the main goal. At the same time, a rationalization of the current high levels of budget and project support for the education sector from external donors is critical. A proliferation of projects and initiatives in recent years is predominantly supply-driven, and their sustainability and potential impact are not aligned with the overall goal of developing the education system. Too often, there is no built-in impact evaluation envisaged in these projects and programs. When evaluations are conducted, they tend to focus on inputs to the school system rather than on student learning outcomes or on the system's institutional capacity. In addition to the lack of performance monitoring, and, therefore, lack of answers regarding the potential impact of such programs, the proliferation of these uncoordinated interventions have also created disincentives for introducing efficiency measures in the use of financial and human resources.

Serious efforts should be made to achieve closer donor coordination and considerably reduced reliance on the project support modality. A sector-wide approach with basket funding should become the main source of external support over the next five years. Appropriate mechanisms to inform policy decision-making must be institutionalized and sustained. Increased political emphasis—and corresponding financial investment—for the impact evaluation of programs and projects will provide the necessary evidence for policymakers to decide what programs to keep or drop, which to scale up, which to adapt or review, and so on. This should apply for government as well as donor initiatives.

Efficiency in the Use of Human and Financial Resources. An analysis of the demographic profile within Palestine may allow the PA to recognize considerable savings. The PA appears to have encountered a demographic bulge rather than a sustained expansion, which will allow it to forgo the recruitment of thousands of new teachers each year. Enrollments were actually lower in grades 1–3 in 2005/06 than they were in 1999/2000. (In contrast, enrollment in grades 10–13 increased by well over 60 percent during the same period.) If such findings are true, the PA could potentially save as much as $17 million per year by reducing its intake from 2,800 new teachers annually and limiting recruitment to replacements only (around 215 per year). More modest decreases projected on 2 and 4 percent a year growth would also yield savings over current practices, albeit at reduced rates. Personnel recruitment for education should not include categories such as administrative and support staff.

A more unified and coherent schooling system with larger schools offering complete elementary, preparatory and secondary cycles would considerably improve the efficiency of service delivery in the education sector. The high proportion of small classes in government schools in the West Bank significantly increases unit costs. Finding ways to ensure that all classes have at least 35–40 students would lead to major efficiency gains, as well as having a more rational deployment of teachers. Larger classes can be achieved through greater teacher flexibility—reliance on class teachers for the lower basic school grades and multi-grade teaching so that small classes can be combined. Effective multi-grade teaching results in both improved learning outcomes (as a result of the introduction of student-centered learning methodologies) and more efficient teacher utilization, and thus significantly lowers unit costs. In addition, class teaching has been found to be more effective than subject teaching among younger aged children in most situations. For this reason, class teachers are the norm in primary schools in most countries. Increased reliance on class teaching, at least up to grade 6, would also substantially improve teacher utilization and overall resource efficiency.

Likewise, the current policy of annual replacement of textbooks is costly and unlikely to be financially sustainable. Increasing the lifetime of textbooks should be seriously considered; three years is the norm in many countries.[76]

Improving the Quality of Basic Education. Quality improvement is clearly the main policy objective for the next five years. Research evidence on determinants of student achievement is consistently pointing to classroom variables and teacher behavior in the classroom as having greater impact than school-wide variables or even system-wide inputs. This means that the emphasis should be on improving pedagogy and methodology, introducing innovations in learning technology, developing classroom management skills in teachers aimed at a more efficient use of time, focusing on school-based monitoring and evaluation and emphasizing the centrality of students in their own learning process.

Towards this end a set of policy reforms should be implemented, including:[77]

- Re-shifting the centrality of textbooks in the curriculum, and the production and dissemination of alternative curriculum materials, teaching aids, school libraries, science laboratories and ICTs.
- Strengthening monitoring and evaluation capabilities at all levels.
- Reform of pre-service and in-service teacher training and development of a national strategy for teacher development.
- Revision by the Agency of Accreditation and Quality Assurance of pre-service teacher training programs, and the technical profiles used for their selection.

[76] Textbooks that are designed to last for three years or more are more costly, but these additional costs are significantly offset by reduced annual replacement expenditure.

[77] A detailed and comprehensive plan to develop such programs is included in the education report: "Impressive Achievements Under Harsh Conditions and the Way Forward to Consolidate a Quality Education System" (World Bank 2006).

- Linking in-service teacher training to decentralized school-improvement policies.
- Developing a system of school indicators of quality improvement.

School Management. Currently, basic schools in the West Bank & Gaza do not face strong incentives to improve quality and learning outcomes. It is important to introduce performance evaluations at the end of the primary cycle to increase the accountability of schools to students and parents and the communities in which they live, as well to create a stronger sense of partnership and ownership. School management committees with significant parental and community representation and considerable decision-making powers could be introduced in order to achieve this. It is important to address government and donor-financed programs and projects directly to strengthening the capacity of schools by enhancing leadership; increasing autonomy for planning and implementation; opening up to the community; favoring partnerships with universities, NGOs and other institutions in the civil society and engaging in school development and improvement projects with the necessary incentives. This necessarily entails a process of political and administrative decentralization and changes in the overall governance and management of the school system.

Box 5.1: Education Policy Recommendations

Broader Strategic Objectives:

- MOEHE's spending pattern should shift from construction, textbooks and increasing the number of teachers to a more sophisticated set of policies to develop pedagogical methods and practices and monitor the quality of service delivery.
- Recruitment should focus exclusively upon areas of critical need (such as secondary school teachers) and avoid categories such as administrative and support staff.

Efficiency in the Use of Human and Financial Resources:

- School size should be increased, particularly in the West Bank.
- MOEHE needs to provide a coherent schooling supply with schools offering complete primary cycles.
- Shifting demographic trends are likely to result in the need to recruit significantly lower numbers of teachers than has been the case previously, curbing the rapid increase in the wage bill.
- On recurrent expenditures, important savings can be made by increasing the lifespan of textbooks and reducing the costs of examinations.
- The introduction of multi-grade teaching will reduce the burden on salaries and improve the quality of teaching.

Providing Equitable Access to Secondary Education:

- Secondary schooling should be the main area of expansion, with enrollments expected to grow over the next five years if all children are accommodated.
- The inequitable distribution of resources between West Bank and Gaza, especially in deployment and training of teachers, computers and library resources, must be addressed.

Improving the Quality of Education:

- Important reforms should be made in the allocation of resources through well-designed policy interventions:
- Shifting the emphasis of textbooks in the curriculum to the production and dissemination of alternative curriculum materials, teaching aids, school libraries, science laboratories and ICTs.
- Reforming pre-service and in-service teacher training and development of a national strategy for teacher development.
- Revising pre-service teacher training programs, and the technical profiles used for their selection, by the Agency of Accreditation and Quality Assurance.
- Linking in-service teacher training to decentralized school-improvement policies.
- Developing a system of school indicators for quality improvement.

Strengthen Monitoring and Evaluation Capabilities at all Levels:

- Emphasize school system results and focus on monitoring student learning outcomes.
- Conduct an impact evaluation of the in-service training provided to teachers through the implementation of the new curriculum.
- Enhance the capacity of universities to monitor and evaluate both students and programs and, in general, perform education research.

Managing the Education System Efficiently and with Transparency:

- Develop donor coordination and harmonization to prevent duplication of actions and waste of resources.
- Use careful impact evaluation of donor and PA programs as the main driver for policy decisions.
- Use a sector-wide approach with basket funding as the main modality for external support over the next five years to increase the potential of achieving impact results and support system-wide development.

Improving Relevance of Education: Reform of Vocational Education at Secondary and Tertiary Level

- Reform vocational education at secondary and tertiary levels to improve employment options for graduates.
- Increase the relevance of education through close collaboration with the private sector and a careful analysis of labor markets.

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(December 4-20, 2005 November 1-10 2005 and March 1-13, 2006)

Ministry of Education and Higher Education:

- Ali Abuzeid, Director of General Education Department.
- Alia Sha'ar, Consultant
- Amer Sabbah, Department of Training and Supervision
- Amira-Meela Rimewai, Principal, Kuper Secondary School for Girls
- Amjad Al-Masri, Director of Information Technology Department
- Basri Saleh, Director General, International and Public Affairs
- Deeb Haddad, Deputy Directo of Ramallah Education District
- Fahoum Shalabi, Director General, Development & Scientific Research
- Fateh El-Ramahi, Principal, Primary School in Ramallah
- Fawaz Mujahed, Director General Department of Construction
- Frosse Dabit, Director, International Relations, Higher Education Sector
- Gabi Baramki, Vice President, Higher Education Council
- Haifa'a F. El-Agha, Director General General Education, Gaza Strip
- Ihab Shukri, Director of School Health Education
- Ilham A. Muhessein, General Director Assistant, General Education
- Imen Hamayel, Principal, Secondary School for Girls (Spanish school)
- Ismail Faleh, Head of Division of Education Statistics
- Jamal Tarif, Director General Department of Examinations and Educational Assessment
- Jehad Draidi, Director, Project Unit Department
- Jehad Nazzal, Department of General Education
- Jehad Zakarna, Assistant Deputy Minister
- Kahramen Arafa, Director of the PR Department, National Training Institute
- Kayed Subhi, Director General of Education Technologies and Information Technology
- Lina Tutunji, Director, Project Management Unit MOEHE, World Bank
- Mahmoud Saleh, Acting Dean of Ramallah Girls College.
- Mohammad Jubran , Director General, Finance
- Mohammed Mustafa, Director, Assessment and Evaluation Center
- Mohammed O.M. Mustafa, Director, Assessment and Evaluation Centre.
- Naser H. Awad, Director, Vocational and Technical Education.
- Othman Amer, Head of English Language Division, Curriculum Development Center
- Rabah Salameh, Assessement and Evaluation Center
- Raida Dahadha, Principal of Abuqash Girls Primary School
- Rima M. Zeid Al-Keilani, Director General, Counseling Department
- Sa'adeh Hamoudeh, Director General, Department of Planning
- Saed Radwan, Director of Examination Results
- Said Assaf, Deputy Assistant Minister for Programs
- Said Jamjum, Head, Al-Ommah Community College.
- Salah Yassin, Director General, Curriculum Development Centre
- Samar M. El-Shorafa, Financial Manager, Gaza Strip
- Sofia Rimawi, National Training Institute
- Shahnaz El-Faar, Director, National Training Institute
- Tawfiq Deeb, Director, Department of Planning

- Tharwat Zied, Director General of Training and Supervision
- Ziad Jweiles, Director General Department of TVET
- Ziad Jweiles, Director General Department of Technical and Vocational Education and Training

Ministry of Finance:

- Farid Ghannam, Budget Director
- Mazen Jadallah, Head, International Relations Department
- Mohammed Harashih, Payroll Directorate
- Salam Fayyad, Minister

Ministry of Planning:

- Cairo Arafat, Director General

Ministry of Labor:

- Salah Alzaroo, Director General

Palestinian Universities:

- Abdul-Ghaffar Bader, Dean, Ibrahimieh Community College.
- Adnan Rashid Manassra, Assistant to the President for Development and Planning, Al-Quds University
- Ahmad Al Farajeen, Head, Modern Community College
- Ismael Khalil, Finance Director, Al-Quds Open University
- Khuloud Khayyat Dajani, Executive President Assistant, AlQuds University
- Maher Hashweh, Chair, Department of Education & Psychology, Birzeit University
- Mohammed Omran, Dean / Principal, Ramallah Men's Training Center
- Muhannad Beidas, Chief, Field Education Program, UNRWA
- Musa Bajali, Al-Quds University
- Ramzi Rihan, Vice-President for Planning and Development, Birzeit University.
- Salah Sh. Soubani, Director of Information and Research Department, Al-Quds Open University
- Sami El-Yousef, Financial Vice-President, Bethlehem University.

- Samir Abdullah, Director General, Palestine Economic Policy Research Institute
- Sufian Kamal, Vice President for Academic Affairs, Al-Quds Open University
- Tafeeda Jarbawi, Principal Ramallah Women's Training College, UNRWA.

Palestinian Organizations:

- Amin Ahmad Mustaffa Dreidi, Direrctor General, Administration and Finance, PCBS
- Fouad Moughrabi, Director, Qattan Centre for Educational Research
- Jehad Mandan, Vice Chairman, General Personnel Council
- Liana Jabr, Qattan Center for Educational Research
- Loay Shabaneh, President, PCBS
- Maher Sbieh, PCBS

- Musa Khaldi, Qattan Center for Educational Research
- Nancy Mahmood, Teacher Creativity Center
- Wasim Kurdi, Qattan Center for Educational Research

Donors:

- Christopher Nordahl, Deputy Director of Operations, Gaza, UNRWA
- Constanza Farina, Head of Office, UNESCO
- Dan Rohrmann, Special Representative, UNICEF
- Emadeddin Abdallah, Political, Financial and Administrative Advisor, Representative Office of Norway
- Joel Toujas-Bernate, Senior Resident Representative, International Monetary Fund

CHAPTER 6: THE HEALTH SECTOR

1. Key Issues and Challenges

Over the past decade, the Palestinian population has been able to enjoy a quality of health care that compares favorably with many other middle income countries. This progress is now at risk from a variety of external and internal factors. With a per capita GDP about a third below the pre-*intifada* level, Palestinian society is confronted with a critical challenge in meeting the health needs of the population.[78] The weakened economic situation has been complicated by geographic fragmentation and checkpoint closures, which have hampered the predictable movement of goods and people and diminished access to basic social services, including health care. A rapid expansion in the wage bill, coupled with a major increase in contracting services, has eliminated any discretionary spending that the PA may have enjoyed and made it completely dependent on donors for virtually all non-salary expenditures.

Prior to the *intifada*, the Ministry of Health (MOH), along with the United Nations Relief Works Agency (UNRWA) and the NGOs, provided an extensive and complementary program of public health services and clinical health care. The health system in the West Bank and Gaza achieved high levels of immunization coverage, prenatal care and effective basic health services. Reflecting these achievements, Palestinian health indicators in 2000 compared favorably with countries at similar income levels in terms of child health, child nutrition, maternal health and life expectancy. However, these achievements came at a relatively high cost, with total health spending at about 13 percent of GDP—among the highest rates in the MENA region. The major concerns in the health sector prior to the *intifada* were improving the efficiency and quality of health care services to contain health spending while responding to the changing epidemiological profile of the population.

During the first years of the post-*intifada* period, the PA managed to maintain a pre-*intifada* level of budget for health programs due to generous budget support from the donor community. Between 1994 and 2000 annual donor disbursements averaged around $500 million (or $150 per capita). At the onset of the *intifada* donors significantly stepped up assistance to the Palestinians, doubling it to around $1 billion annually in 2001 and 2002 (World Bank 2004b). Between 2001 and 2003 it is estimated that donor contributions added about 30 percent to the GDP and over 20 percent to the average Palestinian persons' disposable income. Donor spending on humanitarian and welfare assistance peaked in 2003 but has since declined sharply.

Other health service providers besides the PA, like UNRWA (which is mandated to provide basic education, health and social services to some 1.6 million registered refugees in the West Bank and Gaza), have increased their operations in response to the *intifada* and attempted to mobilize additional resources through emergency appeals. But

[78] According to World Bank estimates, real GDP per capita in 2005 was some 35 percent below its pre-*intifada* level of $1,184 in 1999.

UNRWA had difficulty securing adequate funding for its emergency operations despite active campaigns, and its overall budget has declined in recent years. NGOs have historically played a key role in providing health services in the West Bank and Gaza, and they have been financed largely through donor assistance and private contributions. However, with the outbreak of *intifada*, a significant share of the donor funding shifted towards direct support to the PA. According to 2004 data from the Ministry of Planning, NGOs received just 6 percent of overall emergency support. Within the health sector, a number of NGOs have increasingly come to depend on contracts with the PA as an important source of revenue.

Notwithstanding the generous contributions by the donor community, the accessibility and the quality of Palestinian health services has suffered during the *intifada*. Strains on the system are reflected in slowly declining health indicators. Closures and roadblocks have delayed or prevented pregnant women and other patients from reaching hospitals or maternity centers. In May 2004 MOH reported that 106 patients had died at Israeli roadblocks since the beginning of the *intifada* and 55 births occurred at Israeli checkpoints, resulting in the death of 33 newborn infants (Ministry of Health 2004). According to the Health, Development, Information and Policy Institute, prenatal care coverage has declined while homebirths have increased nearly ten-fold, particularly in rural areas, contributing to a rise in the number of stillbirths (2004).

The deterioration in the public health system is also evident in the increased incidence of waterborne communicable diseases, particularly among children. Between 2000–04 gastrointestinal infections in children under five have increased 42 percent, and the prevalence of amoeba and *giardia* increased by 40–60 percent. The Ministry of Health has also reported isolated outbreaks of communicable diseases not normally seen in the West Bank and Gaza, such as bacterial and viral meningitis. Child health has been particularly affected by the *intifada*; according to one study, malnutrition rates have increased from 8 percent stunting in 2000 to 9 percent in 2002, and from 1.4 percent wasting in 2000 to 2.5 percent in 2002 (Zehraoui 2004).[79] Disabilities—a longstanding health problem in the West Bank and Gaza as a result of conflict-related trauma and high rates of congenital conditions—have risen significantly since the start of the *intifada*. Accurate figures are not available, but estimates of permanent disabilities resulting from conflict-related trauma range from 2,500 to 25,000.[80] This newly disabled group, as well as other disabled persons numbering more than 46,000, require special programs for rehabilitation and social support (MOH 2003).

Decreased access to care and to preventive programs contributes to the increased incidence of chronic conditions, such as diabetes, cardiovascular diseases and renal

[79] "Stunting" (low height for age) reflects chronic malnutrition and is a cumulative measure of past nutritional problems and is considered to be the best measure of malnutrition. Chronic malnutrition as measured by height for age is linked to acute malnutrition (weight for height) in that repeated loss of weight in the short term will translate into reduced height in the long term. "Wasting" (low weight for height) reflects recent illness and/or decreased food intake, often due to the anorexia that accompanies an episode of infection or a decline in the availability of food. Wasting, often called acute malnutrition occurs during seasonal fluctuations and in emergencies.

[80] See the Health, Development, Information and Policy Institute website.

failure, and poorer treatment outcomes. Since most patients are not adequately screened by the health system for these conditions, an increase in morbidity rates among the chronic patients is not yet fully reflected in the health surveillance system. Disabilities resulting from these chronic conditions present an additional burden on the overstretched system.

In addition, some of the consequences of the *intifada* undermine the sustainability of the Palestinian health financing system. On the revenue side, the PA depends on supplements from premium contributions and co-payments collected through the Government Health Insurance (GHI) system. The GHI program, established under the MOH in the 1990s, was expected to provide a sustainable financing mechanism in the form of a social health insurance system that would cover the entire Palestinian population. At its peak in 2000, the GHI contributions covered some 51 percent of the MOH expenditures, and the GHI was poised to expand its revenue base in line with the projected economic growth. But a number of important structural reforms to the GHI system initiated in the late 1990s have been halted since 2000, and emergency measures introduced by the PA to cope with the exigencies of the *intifada* have further undermined its financial sustainability. With the outbreak of the *intifada*, GHI contributions declined while the number of GHI beneficiaries exempted from contributing premiums and co-payments increased as a result of the emergency measure decreed by President Arafat. Although the GHI revenues appear to have recovered in recent years—covering about one-third of MOH's expenditures in 2004—this may largely reflect an increase in contributions from the expanded civil service staff, who are receiving salaries heavily subsidized by donor contributions. Hence, the additional GHI revenues may not signify greater diversification of its revenue base.

The recent rise in public health expenditure has been driven by increasing public employment and wage expenditures, along with a lack of fiscal constraint. Since the *intifada*, the PA has essentially used public employment salaries as welfare payments to inject critical demand into the economy. Between 1999 and 2004 expenditures on public sector wages increased by an estimated 64 percent, with a 28 percent increase between 2002 and 2004 (World Bank 2004a). Health expenditure has also been driven by increasing public salary expenditures, with close to zero funding for capital expenditures and a diminishing share allocated to operating costs. Between 2000 and 2005 the number of medical personnel (physicians, dentists and pharmacists) working for the MOH nearly doubled from 1,631 to 2,999 individuals, and the number of administrators increased by 22 percent from 2,457 to 3,158 persons. This has substantially inflated the wage bill within a relatively flat budget envelope, leading to deficit spending in this budget category. While this approach may have been justified as an emergency measure during the early days of *intifada*, the practice of increasing civil service staffing while cutting operating costs is undermining the effectiveness of public health services and programs.

The PA was able to expand the volume and types of contracts with NGO health care providers through the GHI coverage. The expansion of contracting enabled PA to extend the GHI coverage for beneficiaries in areas where the MOH did not have facilities. It also helped to supplement the revenues for NGOs who were suffering from reductions in

donor financing and private contributions. However, in the face of current fiscal crisis, the MOH has been unable to fully reimburse the NGOs for services rendered under the existing contracts, and the PA is now accumulating sizeable arrears due to these commitments. While it was the original intention of the GHI program to expand the choice of health providers to the beneficiaries by contracting health services to NGOs and private health care providers, this step would have required a substantial upgrade in the GHI's capacity to design, manage and monitor contracts with external health care providers. Expenditure for specialized treatment ballooned from $8 million in 2002 to $55 million in 2005. Referrals for specialized treatment outside of the MOH, both within and outside of the West Bank and Gaza territories, represented 26 percent of total PA health expenditures and 44 percent of non-salary operating expenditures.

PA's expansive policies on salaries and contracted services has effectively left little fiscal space for critical variable expenditure items such as pharmaceuticals, medical supplies and operating costs for equipment and facilities. Many facilities have capacities that are not fully utilized. Moreover, PA spending on these items appears to be poorly executed—for example, the prices the PA pays for drugs are significantly above both world market prices and those paid by UNRWA. Capital investments have been left largely to donor assistance, but to avoid fragmentation, this will require a well-conceived medium term investment plan that is consistent with sectoral priorities, affordable and conditioned on the availability of an adequate operating and maintenance budget. For example, medical equipment is largely provided by donors, but the coordination of these donations has been limited and the MOH has not been able to estimate and allocate adequate resources for the management and maintenance of equipment.

Similar inefficiency appears to be occurring for UNRWA and NGO providers. There are opportunities for efficiency gains within the sub-sectors (PA, UNRWA and NGO) as well as through better coordination of services and resource allocation across these sub-sectors. This calls for strategic and coordinated support to the Palestinian health system that takes into account the complementarity of all service providers, as well as the allocative efficiency within each set of providers. For the PA, this will also involve a major policy decision on whether to invest in and expand its own MOH-operated services, or to expand services for the GHI beneficiaries by outsourcing and contracting through NGOs and private providers. Since so much of the PA budget depends on donor contributions, donor preferences will also play a key role in determining the direction of PA's budget allocation—though this element should diminish as the PA assumes more direct control over the sector.

Finally, shortcomings in the PA's financial management system, including a lack of transparency in the existing accounting system, severely hamper the MOH's ability to effectively monitor and manage its financial resources. In particular, the reliance on cash accounting prevents the Ministry from having a full and accurate picture of outstanding commitments.

2. Priorities for the Health Sector

In the most recent National Health Strategic Plan (NHSP), for 1999–03, the PA committed itself to provide adequate and affordable health care accessible to all Palestinians in an economically sustainable manner. Considerable achievements were made, reflected in the improvement of health indices, service expansion and broader health insurance coverage. In the first three years of the *intifada*, there was a lapse in the medium term planning process while the PA remained in emergency mode. Prospects for improved economic outlook in 2005 led to the preparation of a new Medium Term Development Plan (MTDP) covering the period 2006–08. This MTDP proposes a set of development priorities for the health sector (described in box 6.1) as a component of the national strategy for sustainable human development.

Box 6.1: Priorities for the Health Sector from 2006–08

- Provide sufficient quantities of medication and treatment, maintain a strategic reserve for contingencies and offer annual vaccines for children.
- Work on developing programs to improve nutrition in Palestinian society, particularly among women and children.
- Support training and continuing education for health sector workers.
- Support and develop existing facilities and resources in the field of capacity building.
- Provide sufficient funds to attract the specialized and efficient technicians and doctors that the health sector needs.
- Work to develop an integrated health insurance system.
- Enhance the health sector's administrative and financial systems.
- Approve and activate health laws and regulations, such as the public health law, health insurance law, trade unions law, Palestinian Medical Board Law and the environmental protection law.
- Develop "Woman and Child" health programs, including reproductive health services, pre-natal care and child care.
- Develop programs for youth on sexual health and reproduction.
- Develop programs to fight social problems such as alcoholism, drug addiction and smoking.

Source: Ministry of Planning, Medium Term Development Plan 2006–08.

The MTDP acknowledges the challenges posed to the Palestinian health sector, especially the reduced access and availability of certain health services and the increased cost of health care provision due to geographic and institutional fragmentation. The MTDP underlines the government's responsibility for providing the population with basic services and recognizes that to realize these service delivery goals, it will be necessary for the health care system's main institutions, the MOH, national and private health institutions, NGOs and UNRWA, to cooperate closely.

3. Overall Trends in Health Spending

Public Expenditure in Health. The MOH budget is a traditional input-output budget with economic categories for expenditure classification. The recurrent budget is divided into salary and non-salary expenditure. Non-salary expenditures include utilities,

maintenance, consumables and special treatment referrals. Between 2000 and 2005 public health expenditure increased significantly, mainly due to an expansion in recurrent expenditures (table 6.1). Little to nothing is known about investment expenditure, although given the precarious financial situation in the West Bank & Gaza since the second *intifada*, capital investments have probably been given a lower priority. However, there are investments in new health facilities and maintenance, and upgrades in existing facilities, that take place through specific donor investment projects and do not show up on the MOH balance sheets.

One of the most striking observations in table 6.1 is that public health expenditure has expanded rapidly since 2000 while GDP contracted substantially. Even though GDP has been recovering slowly to pre-*intifada* levels in the last two years, public health expenditure occupies a large and increasing proportion of all public expenditure and GDP. About 8–11 percent of total public funds were allocated to the MOH annually between 2000 and 2006. And since 2003, actual health expenditures have continuously exceeded budget allocations.[81] The difference between budget and actual expenditure was the largest in 2005. The per capita budget increased slightly in nominal terms and, adjusted for inflation, real per capita public health spending has risen steadily since 2002. In all but one of the previous ten years, salary expenditure exceeded the budget allocation—increasingly so since 2003. Non-salary expenditure was usually lower than the budgeted amounts; however, in 2005, non-salary expenditure also exceeded the budget allocation.

For public expenditure in health, the main concern is the growth of salary expenditure as a proportion of total recurrent expenditure. Budget provision for salaries was more or less static between 2000 and 2003, but since then it has increased sharply. Actual salary expenditure rose nearly every year. Salaries as a proportion of budget expenditure increased from 52 percent to 60 percent between 2000 and 2004. In 2005 this trend relaxed slightly, with salary expenditure decreasing to 54 percent of total recurrent expenditure. This was mainly because 2005 was the first year when non-salary expenditure substantially increased. In every year but 2005, the proportion of actual salary expenditure was higher than the proportion of budget salary expenditure, implying low budget discipline. Until recently, there seemed to be only sporadic budget pressure on non-salary expenditure. This is because the majority of the non-salary budget comes from external donor funds, and until recently donors were generally willing to fill this gap.

Similar trends appear to be occurring in UNRWA and other NGO providers of health services. UNRWA has difficulty securing adequate funding to meet all the emergency operations needs, in spite of active campaigns to mobilize additional resources, and its overall budget level has declined in recent years. However, UNRWA's salary

[81] The MOH argues that there were essentially two reasons why actual expenditures exceeded allocations. The first is that the allocations in the budget did not reflect the needs of the ministry, but were determined by the MOF without adequately taking the MOH's needs and priorities into consideration. Second, there was an increase in emergency expenditures as a result of the *intifada*, for which there are no adequate budgetary provisions.

expenditure increased steadily in total and as a proportion of overall expenditure (see box 6.2).

Box 6.2: United Nations Relief Works Agency

UNRWA's mandate is to be a principal agent for the human development of over 4 million Palestinian refugees (22 percent in Gaza and 16 percent in the West Bank). While it has achieved some notable accomplishments, the resource indicators that once symbolized UNRWA's success are now in decline. Education and health facilities are often overcrowded and under-equipped. The intended beneficiaries are increasingly falling through the gaps in service provision (UNRWA 2005). Health resource indicators compare unfavorably with those of the PA (see table 1).

Box table 1 UNRWA's Resource Indicators in Comparison with West Bank and Gaza Host Authority, 2003

Indicators	Palestine	UNRWA	
	Ministry of Health	West Bank	Gaza
Number of Primary Health Care facilities per 100,000 people	29	5.3	1.9
Number of doctors per 100,000 people	84	10.0	9.85
Number of dentists per 100,000 people	8	2.0	1.5
Number of nurses per 100,000 people	141	32.4	27.1
Per capita allocations for health in US dollars	26.9	14.7	12.8

Source: UNRWA 2005.

UNRWA explains this development by noting that the worsening economic situation has forced better-off Palestinian refugees to return to the already overcrowded UNRWA system. In the first months of 2006, for example, the demand for in-patient services increased sharply; it is expected that demand for out-patient services will follow this trend. Other factors may also contribute to this decline. UNRWA's total expenditure in West Bank and Gaza has decreased slightly since 2003. At the same time, salary expenditure increased steadily every year (box table 2). In the health sector, the number of employees increased from 949 in 2002 to 1,139 in 2004 (MOH 2003, 2005). UNRWA confirmed that it is giving priority to staff stability and continued hiring over other efficiency consideration, such as adequate operating expenses. In 2006 UNRWA received record application numbers for their newly advertised positions. While UNRWA's salaries are higher than those of the PA, they are much lower than in other NGOs and UN agencies. In fact, UNRWA is struggling not to lose well-qualified staff. Many doctors and other personnel have to pursue outside employment after their regular working hours at UNRWA.

Box table 2 United Nations Relief Works Agency's Expenditure Trend in the West Bank and Gaza, 2002–05

	2002	2003	2004	2005
Total expenditure	12,710	13,307	12,321	12,997
Salaries (excluding Qalqilia Hospital)	4,401	4,569	4,719	5,166
Medical supplies	2,375	2,515	2,453	1,992

Source: World Bank staff calculations with UNRWA data, 2006.

In general, UNRWA appears to face challenges similar to the PA's—a shrinking budget envelope with an expanding proportion of salary expenditure. The expansion of the salary budget share puts increasing pressure on non-salary expenditure and undermines UNRWA's ability to provide good quality services.

Table 6.1: Budget and Actual Public Health Expenditure, 2000-2006

(current, millions of exchange rate US dollars)

	2000		2001		2002		2003		2004		2005		2006
	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget[1]
Public health expenditure	94	95	99	91	96	88	108	122	126	129	126	157	189
Recurrent expenditure	92	93	97	90	96	87	108	122	126	128	123	155	187
Salaries	45	48	47	55	51	49	57	57	74	77	73	83	95
Non-salaries	47	46	50	35	45	38	51	65	52	51	50	71	92
Investment expenditure	2	6	2	1	0	1	0	0	0	1	3	2	3
Public health expenditure as percent of total public expenditure		8		8		9		11		9		10	
Per capita		30		28		26		35		35		42	
Per capita (real)		29		27		24		33		34		40	
Memo items													
Consumer Price Index		2.7		1.2		5.7		4.4		3.0		3.5	
Exchange rate (NIS/$)		4.08		4.21		4.74		4.54		4.47		4.53	4.67
GDP (million)		4,636		4,034		3,396		3,454		3,765		4,044	
Total public expenditure		1,212		1,120		984		1,140		1,512		1,496	
Population (million)		3.14		3.28		3.39		3.51		3.63		3.76	

1. According to the MOH Finance Department, since 2000 a similar budget plan with almost the same proposed expenditure was prepared on an annual basis and submitted to the Legislative Council for approval. This procedure was initiated for the 2006 budget and the budget plan was submitted to the Legislative Council in August 2005. However, as of May 2006, no new budget was approved. Instead a new budget procedure was initiated. The MOH is now required to submit a budget request on a monthly basis, based on previous year requirements plus a rate of expected budget increase. The budget data for 2006 stems from the proposed budget for the MOH from the MOF.

Source: World Bank staff calculations based on World Bank, MOF and MOH data, 2006.

Data from the MOH that disaggregates public expenditure into sub-categories is shown in table 6.2. This data confirms that, among all recurrent expenditure items, salaries and special treatment referrals increased most significantly. According to table 6.2, by 2005 special treatment referrals accounted for 17 percent of all public health expenditure. However, these numbers only represent the special treatment referrals that were actually paid.[82] The MOF stopped paying contracted providers for special referrals sometime in 2005. Since then, the actual cost for special treatment referrals in 2005 is an estimated $55 million (MOH 2006). That would amount to about 26 percent of all public health expenditure and 44 percent of non-salary recurrent expenditures. There does not appear to be a consistent information flow between the MOH and MOF on special treatment referral costs, nor is an accurate recording system in place. The proportion of salaries comprised about 53 percent of all public expenditure in 2005 (56 percent in 2002).[83]

Table 6.2: Recurrent and Investment Expenditures in Health, 2002-06
(current, millions of US dollars)

	2002		2003		2004		2005		2006
	Budget	Actual	Budget	Actual	Budget	Actual	Budget	Actual	Budget[1]
Recurrent expenditure	96	87	108	122	126	128	123	155	187
Salary	51	49	57	57	74	77	73	83	95
Non-salary	45	38	51	65	52	51	50	71	92
Medical supplies and drugs	25	19	26	20	26	26	25	31	36
Special treatment referrals	6	8	13	31	13	11	11	26	40
Other operating costs	15	11	13	13	13	14	14	14	40
Investment expenditure	0	1	0	0	0	1	3	2	3
Total	96	88	108	122	126	129	126	157	189
Memo item									
Exchange rate (NIS/$)		4.74		4.54		4.47		4.53	4.67

1. Proposed budget, MOF 2006.
Source: World Bank staff calculations based on MOF and MOH data, 2006.

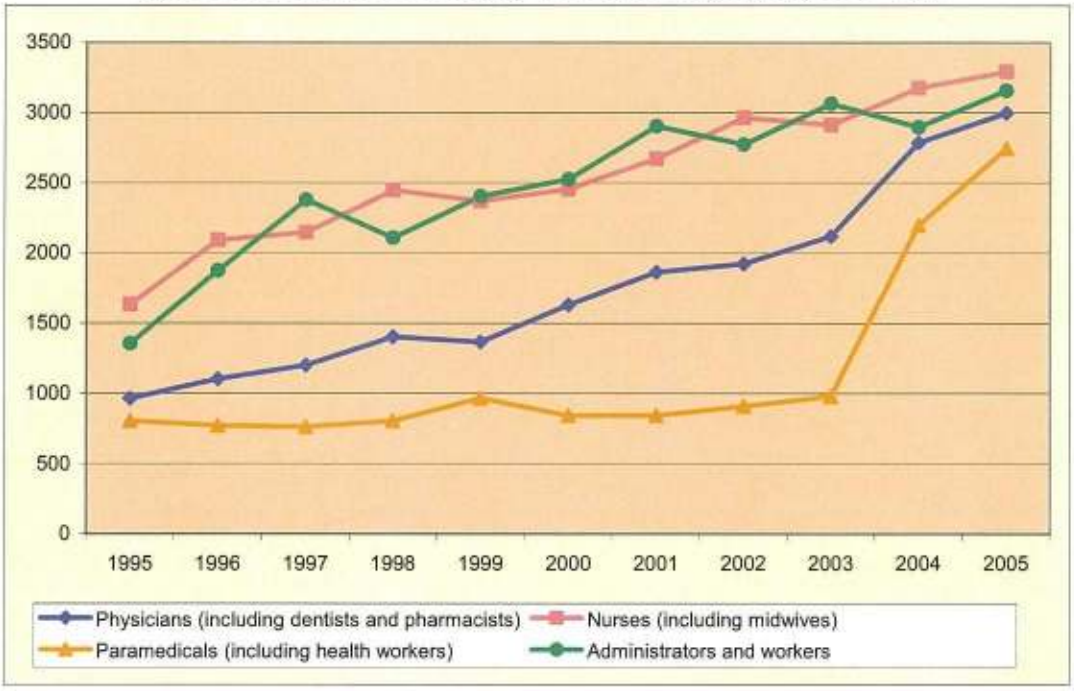
Public health expenditure is occupying an increasing share of public expenditure and GDP, raising serious fiscal sustainability issues for the MOH budget. One particular danger lies in the growing imbalance of salary and non-salary expenditure. Permanently hired staff make it hard to adjust budgets in the short-run when a tighter fiscal policy is necessary.

[82] The figures in table 6.2 show the planned (budget) amount and actual payments, but do not account for the total liabilities due to arrears on unpaid bills. According to MOH, the total cost of contracted services was estimated at about $55 million in 2005, which represents significant arrears of about $30 million for that year. In the absence of accrual accounting, these liabilities are not captured in the MOH budget figures.
[83] This figure was 46 percent in 2003 and 60 percent in 2004.

And increasing non-salary expenditure is required to offset quality concerns where additional staff are not supported with sufficient supplies, like drugs. According to MOH staff, there is also concern about a qualitative shift in expenditure, with the MOH receiving lower value for money and paying the same price for goods and services of diminished quality.

Salaries and Benefits. Both tables 6.1 and 6.2 point towards a dramatic expansion in salary expenditure since 2002. Although budget allocation for salaries increased over the last few years, the actual expenditure for salaries continued to exceed the allocated budget. Much of the increase can be accounted for by new staff hired between 2003 and 2004. There were also reported increases in salaries. The number of MOH employees increased steadily over the last decade (figure 6.1). The most sizeable increase in the number of MOH employees, 18 percent, was between 2003 and 2004. In 2005 the MOH employed a total of 12,197 people, most of them civil servants (11,054 in March 2005 and 11,284 in February 2006).

Figure 6.1: Number of Ministry of Health Employees, 1995–2005



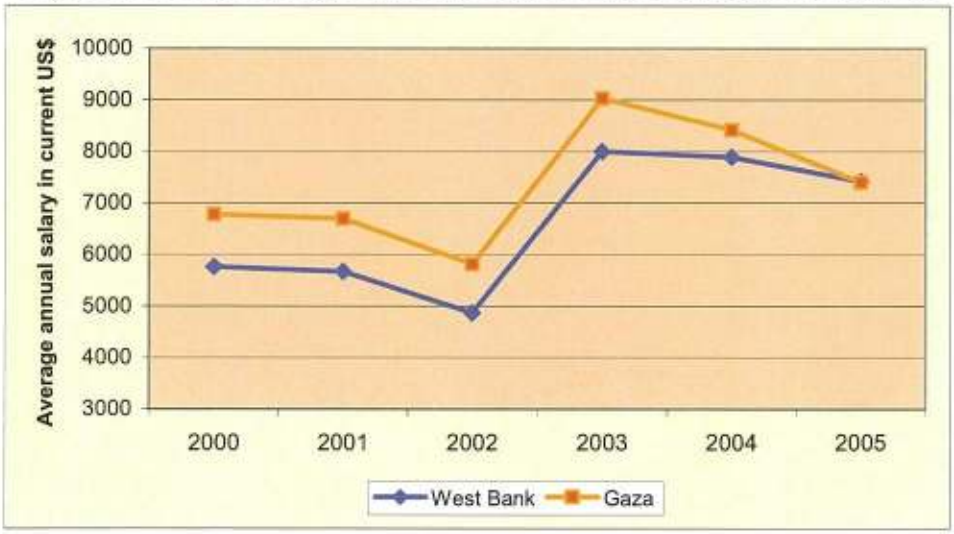
Source: MOH 2003, 2005 and 2006.

The number of employed medical personnel (physicians, dentists and pharmacists) nearly doubled from 1,631 in 2000 to 2,999 in 2005. The other two categories with a high increase were paramedicals and administrators and workers. Paramedicals had one of the largest increases in numbers, more than doubling between 2003 and 2004 from 978 to 2,199.[84] Administrators and workers consistently accounted for about a third of all employees.

[84] Between 2002 and 2004 the number of health employees also increased for UNRWA and NGOs. The sharpest increase was for NGOs, from 4,700 to 6,327. UNRWA's number of employees increased from 949 to 1,139. However, for Medical Services for the Police and Security (MPS) the number of employees

Since 2003 there has been a significant increase in the real average annual salaries of MOH employees (figure 6.2). Gaza salaries are higher on average, since more high-level administrators are located in the Gaza MOH headquarters. Salaries paid are based on the civil service salary system containing 12 different payment grades that vary substantially. For example, in 2005 the real average annual salary for the highest grade employee in the MOH was $36,302 and the lowest grade was $4,169. Doctors earn around $6,000 a year and most of them have to work in their own practices after hours to afford the relatively high living costs in Palestine. This fact is widely confirmed, even though there is a law that prohibits doctors from operating a private practice outside of MOH employment without a license.[85] The MOH also seems to have difficulties in enforcing regular working hours for their physicians and specialists. Given the current crisis situation, where salaries are not paid regularly, it seems likely that it will become even harder to guarantee the presence of health personnel in MOH facilities in the near future.

Figure 6.2: Real Average Annual Salary for MOH Employees, 2000–05



Source: World Bank staff calculations based on MOH data adjusted for inflation, 2006.

Special Medical Treatment Referrals. Figure 6.3 shows a significant increase in the special treatment component of non-salary expenditure.[86] It includes specialized treatment in non-MOH Palestinian institutions, treatment in facilities abroad and expenses for the treatment of patients in MOH facilities by external personnel. Between 2002 and 2004

decreased from 1,001 to 954 (MOH 2003 and 2005). These numbers do not reflect a dramatic increase in health professionals in Palestine. It is widely acknowledged that many doctors, and indeed most other health services personnel, have more than one job.

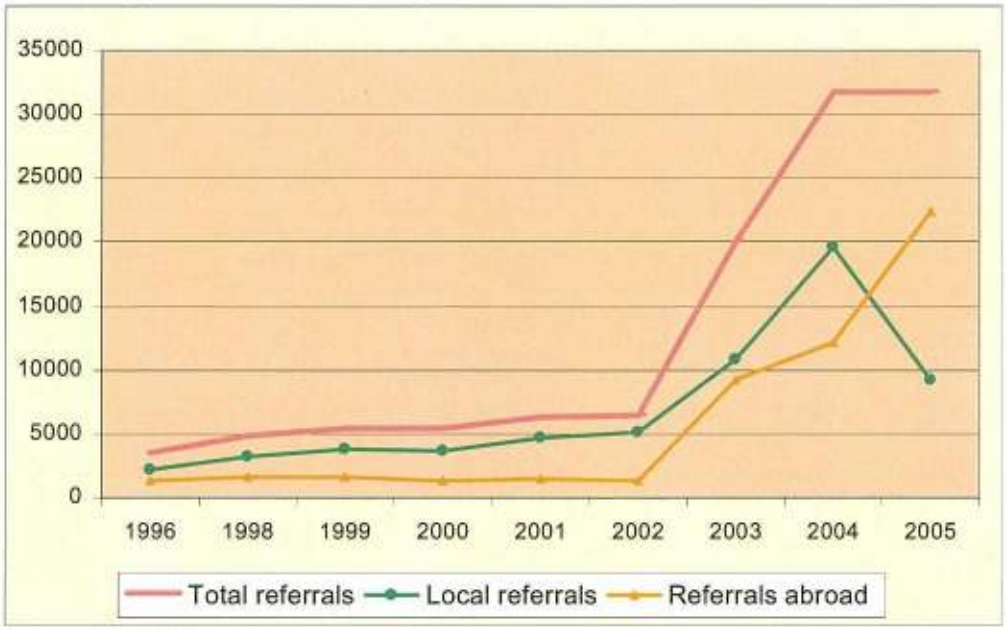
[85] Anecdotal reports also suggest that some physicians might refer the same patients they tend to in the MOH facilities to their private practices. These reports also suggest that most of the expensive diagnostics are performed in the MOH system, including filling necessary prescriptions, while the remainder of the treatment is performed in private practices. This would mean that the public system is indirectly subsidizing private practices, but also that treatment costs are shifted in part to the patient.

[86] Special Treatment is sometimes also referred to as "Treatment Abroad" for historical reasons, although most of the special treatment occurs within West Bank and Gaza territories.

these expenditures increased from $8 to $55 million.[87] Special treatment referrals now account for about a quarter of the MOH budget. Total expenditure on specialized treatment for the sector by the government is considerably higher than these figures indicate, as less than half of the total net expenditure comes from MOH budgets and the remainder comes from the President's Office.

The number of special treatment referrals tripled between 2002 and 2003 from 6,483 to 20,100. It peaked in 2004 with 31,744 referred cases, where it remained in 2005 (figure 6.3). In the first quarter of 2006 there were more than 5,000 new referrals (MOH 2006). Until 2002 local referrals increased steadily while referrals abroad remained around 1,400 cases a year. By the end of the period of the most rapid expansion (between 2000 and 2004), the number of referrals abroad climbed to 12,100, and the number of local referrals to 19,644. However, this trend reverted in 2005, when referrals abroad increased to 22,473 cases and local referrals decreased to 9,245 cases.

Figure 6.3: Number of Special Treatment Referrals, 1996–2005



Source: MOH 2006.

Over the last few years, the leading medical causes for referrals were diseases of the heart (especially heart catheterization), cancer treatment, infertility treatment, eye diseases and rehabilitation treatment. The majority of the patients were in the age group of 15–49 years, followed by the age group of 60+ years (about a quarter).

There are multiple reasons for the increase in special treatment referrals. One is the lack of resources within the MOH facilities, including adequate equipment and medical personnel.

[87] The "total expenditures" on special referrals include the total cost of contracted services, distinct from the actual payments made by MOH to the contracted providers. For example, the estimated cost for special referrals in 2005 is $55 million, of which $26 million has been paid by MOH (see footnote 5 above).

Another reason is the misuse of medical referrals as a means to obtain travel clearance from Israel.

In the past year there have been serious efforts to contain the further increase in medical referrals, especially to prevent the misuse of financial resources in dire need in other areas of the public health sector. In November 2005 a decree was passed to prevent special treatment referrals that fall under the so-called "exemptions."[88] All special referrals now have to be approved by a Medical Committee for Treatment Abroad. This committee contains medical specialists who use objective medical criteria to determine if a referral will be granted.

There are also efforts to improve infrastructure bottlenecks, such as the opening of a new catheterization lab in Gaza and proposed eye disease rehabilitation services in West Bank and Gaza. Before embarking on new public investments, it is necessary to undertake a more comprehensive assessment of the health delivery system to compare the cost-effectiveness of investing in new MOH facilities with the alternative option of contracting NGO or private sector providers within West Bank and Gaza.

Pharmaceuticals. Pharmaceutical costs occupy a significant share of public health expenditure (see box 6.3). The MOH is increasingly unable to pay drug manufacturers and drug providers. Drug availability will soon become an urgent problem and may lead to more special treatment referrals.

Around 17 percent of the $40 per capita pharmaceutical expenditure is spent on antibiotics and another 16 percent is spent on chronic diseases, mainly diabetes and cardiovascular diseases. There is an unequal distribution of drugs and other medical supplies between the West Bank and Gaza. This leads to more shortages in the West Bank, forcing people there to privately seek more expensive drugs or go without.[89]

The laws that regulate the pharmaceutical sector in the West Bank and in Gaza are outdated and deal mainly with the regulation of private pharmacies, drug stores and pharmacy practices. Inconsistency between the laws hinders the development of a unified regulatory framework. Current laws do not make any provision for drug pricing, generic substitutions and drug registration.[90] At time of registration, agents/importers are asked to provide the price of the drug in the country of origin, the export price to Palestine and the suggested price to the consumer (the cost price adds 35 percent wholesaler profit and 15–25 percent

[88] For example, under these exemptions all Palestinians that spent time in an Israeli prison qualified for referrals for infertility treatment. According to officials in the MOH, these referrals stopped by the end of 2005.

[89] After adjusting for population size, Gaza received about 50 percent more drugs per capita than the West Bank over the period 2002–04. It should also be noted that a larger share of the Gaza population's primary health care needs, including drugs, are covered by UNRWA (75 percent as compared to 27 percent of the West Bank). In the past, this higher level of public support may have been justified due to a higher poverty rate in Gaza, but needs to be adjusted due to the increasing poverty rate in the West Bank.

[90] Legislations governing the pharmaceutical sector in the West Bank consist of the Jordanian public health law 43/1966 and the Jordanian pharmaceutical law 10/1957, enacted in June 1967. In Gaza the Egyptian public health law 21/41/1967 is the relevant legislation.

retail pharmacy profit). MOH procurement prices are fairly high and show significant fluctuation. Median price ratios of MOH-procured generics and the lowest priced generic equivalent were 6.9 and 9.7 respectively. MOH average procurement prices were four times the UNRWA average procurement prices for the same period.

Box 6.3: Pharmaceutical Expenditure

Pharmaceutical expenditure accounted for about 20 percent of total health expenditure in 2005. Drug expenditure increased around 50 percent between 2001 and 2005. Obtaining the correct figures on total pharmaceutical expenditure per capita is challenging, since expenditure information is often unavailable from private insurers, small NGOs and charitable societies. Tentative figures indicate a number around $40 per capita, excluding private insurers, NGO hospitals and small NGOs.

Box table 1 Pharmaceutical Expenditure by Provider, 2004–05 (millions of US dollars)

	2004	2005
MOH	17	20.9
UNRWA	6.3	6.5
NGOs (HWC&PMRS)	1.5	1.8
Total	**24.8**	**29.2**

Source: MOH Directorate of Medical Drug Store, West Bank and Gaza, May 2005.

Private Spending on Health. Private health expenditure data is only available from the *Health Expenditure Survey 2004*, which was conducted by the Palestinian Central Bureau of Statistics (PCBS) in August 2004. This is the first comprehensive data collection of its kind on a national scale. Since it was a one time only survey, cross-sectional data is provided but not trend information. Data on household health expenditure was collected from 4,016 households (2,666 in the West Bank and 1,350 in Gaza). The survey covered residents in urban and rural areas and in refugee camps.[91]

PCBS estimated from the survey a per capita health expenditure of $138 in 2003, which corresponded to 13 percent of the GDP. These results also confirm that about one-sixth of all health expenditure is MOH expenditure. The survey also indicates that 80 percent of total health expenditures were made by households. However, this seems unlikely in light of the high level of health financing from external donors and NGOs. The European Community/HERA *Health Sector Review 2003* estimated that 15 percent of funds came from the Palestinian Authority, 37 percent from direct patient payment (including premiums and fees), and 48 percent from external donors. Thus, it seems more likely that household expenditure is around 40 percent of the $138 per capita health expenditure.

According to the PCBS *Health Expenditure Survey 2004,* most households visit a Primary Health Care center (PHC) about once a month (54 percent had at least one household member visit in the past two weeks). Household expenditure related to a PHC visit thus comprises an important component of all household health expenditure. The average cost

[91] Numbers presented here are based on data from the PCBS *Press Conference on the Initial Survey Results: Health Expenditure Survey 2004.* The data refers to the collection period, is not standardized and might include seasonal influences.

per PHC visit in 2004 was $28 for a household, $16 in Gaza and $33 in the West Bank (Table 6.3).[92] All components of the average cost per PHC visit were more expensive in the West Bank, with doctors, lab services and transportation costing three times as much as in Gaza. Expenditures on drugs accounted for 60 percent of all household medical expenditures in Gaza, and 35 percent in the West Bank.

Table 6.3: Composition of Average Household Expenditure per Primary Health Care Visit, 2004

	Gaza		West Bank		Total	
	Cost in US dollars	Percent	Cost in US dollars	percent	Cost in US dollars	percent
Doctors	4	22	12	35	10	34
Medication	10	60	11	35	11	39
Lab services (including X-ray)	1	8	4	12	3	12
Transportation	1	7	3	10	3	9
Other	0	3	2	8	2	6
Total	16	100	33	100	28	100

Source: World Bank staff calculations with PCBS 2004 data.

The average expenditure per PHC visit for a household can vary substantially depending on the provider. Private clinics are the most expensive with average cost per visit of $45 ($39 in Gaza and $46 in the West Bank), followed by NGO PHC centers with cost per visit of $20 ($15 in Gaza and $21 in the West Bank). Private clinics in Gaza are over six times more expensive than government PHC centers. The average cost per PHC visit in all types of PHC centers—other than pharmacies—is more costly in the West Bank than in Gaza (Table 6.4).

Table 6.4: Average Cost per Primary Care Visit by Type of Facility, 2004
(US dollars)

	Gaza	West Bank	Total
Government Maternal Child Health Centers	3	5	5
Government Primary Health Care center	6	17	12
UNRWA Primary Health Care center	4	9	6
NGO Primary Health Care center	15	21	20
Private clinic	39	46	45
Pharmacy	11	11	11
Other	30	23	24
All centers	16	33	28

Source: World Bank staff calculations with PCBS 2004 data.

About 21 percent of households had sought hospital day treatment without admission in the past month. Two in five households (41 percent) had at least one household member

[92] An average of NIS 127, NIS 72 in Gaza and NIS 146 in the West Bank.